Exhibit G

Correspondence: Dr Tun, The Brooklyn Hospital Center, 121 Dekalb Ave, Brooklyn, NY 11220 (htunnm@gmail.com).
Financial Disclosure: None reported.

1. You YN, Xing Y, Feig BW, Chang GJ, Cormier JN. Young-onset colorectal cancer: is it time to pay attention? *Arch Intern Med*. 2012;172(3):287-289.

In reply

We agree that the value and the cost-effectiveness of broadening colorectal cancer (CRC) screening practice to all young adults remain to be determined. Our current analysis,[1] the largest cohort study to date that examined the problem of CRC incidence among adults younger than 50 years, highlights the steadily increasing incidence of CRC in this patient population and adds to recent findings from the Surveillance, Epidemiology and End Results (SEER) program.[2-4] Taken together, we hope that this alarming epidemiologic trend would no longer be dismissed as unimportant. It is our opinion that this observed incidence trend merits greater vigilance in evaluating symptoms consistent with CRC in the young adult population, when health care professionals encounter such a clinical situation.

Clearly, further research is needed to decipher reasons underlying the observed incidence trends of young-onset CRC. Our analysis of risk factors associated with young-onset disease was limited to clinicopathologic factors available from our data source. We agree that smoking, sedentary lifestyle, and diet are established risk factors for CRC but suggest that previous research that identified these risk factors likely included few patients younger than 50 years, and given the current observation of rising incidence in the latter population specifically, we believe that renewed efforts to either affirm the same or identify alternate disease risk factors are warranted. We also believe that many of these cases may be sporadic and cannot be accounted for by known hereditary syndromes because we found that young-onset cases more commonly arose from the distal colon and rectum, while hereditary cases have traditionally been thought to arise more commonly from the proximal colon.[5] Finally, we agree that because a multiple logistic regression model was used, odds ratio rather than hazard ratio would have been the more appropriate term because the latter is usually associated with survival analyses.

In summary, our current analysis[1] aimed to provide the motivation for further research to identify the mechanisms and risk factors for CRC among young adults but was not an attempt to adjudicate a recommendation for universal endoscopic CRC screening.

Y. Nancy You, MD, MHSc

Author Affiliation: Department of Surgical Oncology, The University of Texas MD Anderson Cancer Center, Houston.
Correspondence: Dr You, Department of Surgical Oncology, The University of Texas MD Anderson Cancer Center, 1400 Pressler St, PO Box 301402, Unit 1484, Houston, TX 77230 (ynyou@mdanderson.org).
Financial Disclosure: None reported.

1. You YN, Xing Y, Feig BW, Chang GJ, Cormier JN. Young-onset colorectal cancer: is it time to pay attention? *Arch Intern Med*. 2012;172(3):287-289.
2. Edwards BK, Ward E, Kohler BA, et al. Annual report to the nation on the status of cancer, 1975-2006, featuring colorectal cancer trends and impact of interventions (risk factors, screening, and treatment) to reduce future rates. *Cancer*. 2010;116(3):544-573.
3. O'Connell JB, Maggard MA, Liu JH, Etzioni DA, Livingston EH, Ko CY. Rates of colon and rectal cancers are increasing in young adults. *Am Surg*. 2003; 69(10):866-872.
4. Siegel RL, Jemal A, Ward EM. Increase in incidence of colorectal cancer among young men and women in the United States. *Cancer Epidemiol Biomarkers Prev*. 2009;18(6):1695-1698.
5. Lynch HT, Lynch PM, Lanspa SJ, Snyder CL, Lynch JF, Boland CR. Review of the Lynch syndrome: history, molecular genetics, screening, differential diagnosis, and medicolegal ramifications. *Clin Genet*. 2009;76(1):1-18.

Correction to Article About Prevalence of Fracture and Fragment Embolization of Bard Retrievable Vena Cava Filters

We are writing to inform the readers and editors of the *Archives* that we have discovered errors in our article titled "Prevalence of Fracture and Fragment Embolization of Bard Retrievable Vena Cava Filters and Clinical Implications Including Cardiac Perforation and Tamponade."[1] The 189 patients described in the published study were identified from general surgery and interventional radiology logs and were a subset of all patients who underwent implantation of vena cava filters between 2004 and 2009.[1] Despite requesting complete patient lists from each division, a log of radiology patients who received the Bard G2 filter (Bard Peripheral Vascular) at York Hospital between January 2007 and January 2009 was not made available to investigators, and therefore these patients were not included in the fluoroscopy study. A copy error in Figure 2 incorrectly stated that 83 patients agreed to fluoroscopy. The correct number is 80, as reported in the text, abstract, and statistical calculations of the article. In Table 2, 4 different physicians implanted filters, which went on to fracture, with 10 of these devices implanted by the same physician. While these issues do not have significant bearing on the results reported in our study and do not change our conclusions, we thought that they should be disclosed.

William J. Nicholson, MD

Author Affiliation: Department of Cardiology, York Hospital, York, Pennsylvania.
Correspondence: Dr Nicholson, Department of Cardiology, York Hospital, 1001 S George St, York, PA 17405 (wjnichmd2@aol.com).
Financial Disclosure: None reported.

1. Nicholson W, Nicholson WJ, Tolerico P, et al. Prevalence of fracture and fragment embolization of Bard retrievable vena cava filters and clinical implications including cardiac perforation and tamponade. *Arch Intern Med*. 2010; 170(20):1827-1831.